

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042343

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 132 Primary Registration District No. \_\_\_\_\_ Registrar's No. 225

FILED DEC 14 1962

1. PLACE OF DEATH a. COUNTY <u>GRUNDY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>GRUNDY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>TRENTON TWP</u>		c. CITY OR TOWN <u>SPICKARD</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PLAINVIEW REST HOME</u>		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>ARCHIE THOMPSON WALTON</u>			4. DATE OF DEATH Month Day Year <u>DEC 10 1962</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-1883</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (City and state or country) <u>SLATER MO USA</u>	
13a. FATHER'S NAME <u>ANTHONY WALTON</u>		13b. MOTHER'S MAIDEN NAME <u>KATE THOMPSON</u>		14. NAME OF HUSBAND OR WIFE <u>ELIZA WALTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWI</u>			17. INFORMANT <u>A BERNICE CARTER TRENTON MO.</u>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Fractured 5th Cervical vertebrae at throat</u> DUE TO (c) <u>Patient went to Ellis Hospital with fractured vertebrae</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>Known only</u> <u>2 weeks</u> <u>Month 11-26-62</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>May 25-1962</u> to <u>Dec 10 62</u> and last saw him alive on <u>Dec 10-1962</u> Death occurred at <u>12120</u> <u>A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Archie Walton</u>		22b. ADDRESS <u>Fact Masonic</u>	22c. DATE SIGNED <u>Dec 10 62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-12-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC CEMETERY</u>	23d. LOCATION (City, town, or county) <u>TRENTON MO.</u>
24. FUNERAL DIRECTOR <u>WISE FUNERAL HOME SPICKARD MO</u>		25. DATE RECD. BY LOCAL REG. <u>12-12-62</u>	26. REGISTRAR'S SIGNATURE <u>Dune Jar</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300  
Rev. 4/59

1 0405

2 0405

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9 1992

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12 86-6

13 1-0

DEC 18 1962

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Cross Wise

Licensed Embalmer No. 3771

P. O. Address Spickard Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.